TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-22-1057-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
February 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 17, 2021	99213	$163.14	$0.00
August 17, 2021	99080-73	$15.00	$0.00
	Total	$178.14	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "...the ICD-10 Code, (redacted) sprain of right wrist, that has been billed for, is compensable and is the same code that has been billed and paid on previously and post this date of service."

Amount in Dispute: $178.14

Respondent's Position

"We escalated this review to our bill review vendor and based on additional review have issued payment to Peak Integrated for $171.11."

Response submitted by: Cannon Cochran Management Services, Inc.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.03 sets out the fee guidelines for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services originally for extent of injury. This denial was not maintained upon reconsideration. The insurance carrier reduce the disputed charges with the following claim adjustment codes:

- - Charge exceeds Fee Schedule allowance
- W3 – TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title

Issues

1. Is the insurance carrier's reduction based on fee schedule supported?

Findings

1. The requestor is seeking reimbursement of $178.14 for professional medical services rendered in August 2021.

   DWC Rule 28 TAC §§129.5 (j)(1) states in pertinent part Doctors, delegated physician assistants, or delegated advanced practice registered nurses are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors, delegated physician assistants, or delegated advanced practice registered nurses billing for Work Status Reports as permitted by this section shall do so as follows CPT code "99080" with modifier "73" shall be used when the doctor, delegated physician assistant, or delegated advanced practice registered nurse is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section; The amount of reimbursement shall be $15.

   Review of the submitted documentation found the requestor met the requirements of Rule shown above. Amount recommended is $15.00.

   DWC Rule 28 TAC §134.203 (b) and (c), reimbursement for the services in question are based on Medicare policies using the conversion factor determined by DWC for the appropriate year. The maximum allowable reimbursement is calculated as the CMS Physician Fee Schedule allowable multiplied by the DWC conversion factor divided by DWC 2021 = MAR or $156.11 x 61.17/34.8931 = $156.11.

   The total allowable for the disputed services is $171.11. The insurance carrier provided evidence of a payment of $171.11 made on February 10, 2022. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		April 26, 2022
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.